DATE_____

DMAFB PRESCRIPTION TRANSFER FORM

Use one form per prescription. All transfers take 3 duty days to process.

PATIENT NAME:_____ **Patient's DOB:** ____/____/____
MM DD YEAR

SPONSOR'S Full SSN: ____--____--____ **Patient Contact # (____)**_____

** **Has the Patient Received Medications at Davis-Monthan Previously? Yes / No (circle one)**
Ensure the patient is registered in our system

TRANSFERRING FROM: _____**Pharmacy PHONE #:** _____
(Pharmacy Name / Base)

MEDICATION NAME & STRENGTH: _____
☐ Verify if DAW

RX NUMBER: _____

PHARMACY USE ONLY BELOW

SIG: _____ **QTY:** _____

DATE WRITTEN: _____ **LAST FILL DATE:** _____

ORIG REFILLS: _____ **REMAINING REFILLS:**_____

PROVIDER: _____ **DEGREE: MD NP PA**

NPI NUMBER: _____ **DEA:** _____

OFFICE PHONE: _____

IF Military and no DEA – SSN: _____ **RANK:** _____

FOR CONTROLLED MEDICATIONS ONLY:

Date of Each Fill: _____

Pharmacy DEA #: _____**Pharmacy Address:** _____

☐ **Verbal Read back Completed (Initial Block)**

TRANSFERRED FROM (Full name): _____

PERSON COMPLETING TRANSFER: _____